Addendum A Figures

Figure 2-1-A-1 DD Form 2520

CHAMPUS/CHAMPVA CLAIM FORM

For services or supplies provided by civilian sources of medical care.
Read cover instructions and the back of this form before completing and signing!

Form Approved
OMB No. 0704-0004
Expires Nov 30, 1989

SECTION I - PATIENT INFORMATION

1. PATIENT'S NAME (Last, First, Middle Initial)
2. PATIENT'S DATE OF BIRTH (MMDDYY)
3. PATIENT'S ADDRESS (Street, City, State, and ZIP Code)
TELEPHONE (Include Area Code)
4. PATIENT'S SEX (X one) — MALE / FEMALE
5. PATIENT'S RELATIONSHIP TO SPONSOR (X one) — SELF / SPOUSE / NATURAL OR ADOPTED CHILD / STEPCHILD / OTHER (Specify):
6. MILITARY/VA IDENTIFICATION CARD INFORMATION
a. CARD NO.
b. ISSUE DATE (MMDDYY)
c. EFFECTIVE DATE (MMDDYY)
d. EXPIRATION DATE (MMDDYY)
7. ARE YOU COVERED BY ANY OTHER HEALTH INSURANCE PLAN OR PROGRAM TO INCLUDE HEALTH COVERAGE AVAILABLE THROUGH OTHER FAMILY MEMBERS? IF YES, ENTER NAME OF OTHER PLAN OR PROGRAM. — YES / NO
ADDRESS (Include ZIP Code)
8. TYPE OF COVERAGE (X one)
Employment (Group) / Private Plan-Group / MEDICAID / MEDICARE / Student Plan / Other (Specify)
c. OTHER IDENTIFICATION NUMBER
d. EFFECTIVE DATE (MMDDYY)
e. OTHER PROGRAM THROUGH EMPLOYMENT? EMPLOYER NAME — YES / NO
15. REASON FOR CONDITION (X all that apply) — YES / NO
a. WORK RELATED
b. MILITARY SERVICE RELATED
c. AUTOMOBILE ACCIDENT RELATED
16. INPATIENT/OUTPATIENT CARE
OUTPATIENT / INPATIENT-SKILLED NURSING FACILITY / INPATIENT HOSPITAL WITHIN CATCHMENT AREA (Attach DD Form 1251) / INPATIENT-EMERGENCY / INPATIENT HOSPITAL-OUTSIDE CATCHMENT AREA / PROGRAM FOR THE HANDICAPPED / INPATIENT-OTHER
17. DESCRIBE CONDITION FOR WHICH YOU RECEIVED TREATMENT. IF AN INJURY, NOTE HOW IT HAPPENED.
18. SIGNATURE OF PATIENT OR AUTHORIZED PERSON, CERTIFIES CLAIM INFORMATION AND AUTHORIZES RELEASE OF MEDICAL OR OTHER INSURANCE INFORMATION. READ INSTRUCTIONS ARE REVERSE BEFORE SIGNING.
a. SIGNATURE
b. DATE SIGNED
c. RELATIONSHIP TO PATIENT

SECTION II - SPONSOR INFORMATION

9. SPONSOR'S NAME (Last, First, Middle Initial)
10. SPONSOR'S SOCIAL SECURITY NO. OR VA ID NO.
b. VA STATION NO.
14. SPONSOR'S DUTY STATION OR ADDRESS FOR RETIREES
TELEPHONE (Include Area Code)
11. SPONSOR'S BRANCH OF SERVICE (X one) — USA / USAF / USMC / USN / USCG / USPHS / NOAA / VA
12. SPONSOR'S GRADE/RANK
13. SPONSOR'S STATUS (X one) — ACTIVE DUTY / RETIRED / DECEASED

SECTION III - PHYSICIAN/OTHER PROVIDER (Items 19 through 33 are to be completed by the physician or other provider)

19. REFERRING PHYSICIAN
a. NAME
b. ADDRESS (Include ZIP Code)
c. TELEPHONE (Include Area Code)
d. (X one) — PRIVATE PRACTICE / UNIFORMED SERVICES
20. FACILITY WHERE SERVICES RENDERED (Other than home/office)
a. NAME
b. ADDRESS (Include ZIP Code)
21. PROVIDER OF SERVICES — ATTENDING PHYSICIAN / OTHER (Specify)
22. HOSPITALIZATION INFORMATION
a. ADMISSION DATE (MMDDYY)
b. DISCHARGE DATE (MMDDYY)
23. LAB WORK OUTSIDE YOUR OFFICE? — YES / NO — IF YES, CHARGES:
24. DIAGNOSIS, SYMPTOM OR NATURE OF ILLNESS OR INJURY (Relate diagnosis to procedure on column 27e. by reference to numbers 1, 2, 3, or 4)
1.
2.
3.
25. SERVICES PROVIDED

a. DATES OF SERVICE MMDDYY/YEAR	b. PLACE OF SERVICE	c. PROCEDURE CODE IDENTIFY:	d. DESCRIBE PROCEDURES/SUPPLIES FOR EACH DATE, SUBMIT REPORT EXPLAINING UNUSUAL SERVICES OR CIRCUMSTANCES	e. DIAGNOSIS CODE	f. CHARGES	LEAVE BLANK

26. PATIENT'S ACCOUNT NO.
27. PROVIDER'S SOCIAL SECURITY NO.
28. PROVIDER'S EMPLOYER I.D. NO.
29. PHYSICIAN OR OTHER PROVIDER
a. NAME
b. ADDRESS (Include ZIP Code)
c. TELEPHONE (Include Area Code)
d. PROVIDER NO.
g. TOTAL CHARGES $
30. AMT. PD. BY BENEFICIARY $
31. AMT. PD BY OTHER INSURANCE $
32. AGREEMENT TO PARTICIPATE (Read reverse) — YES / NO
33. PHYSICIAN OR OTHER PROVIDER (Read reverse before signing)
a. SIGNATURE
b. DATE SIGNED

DD Form 2520, DEC 90 *Previous edition may be used.*

Figure 2-1-A-1 DD Form 2520 (Continued)

Item 9: VA Station Number (CHAMPVA only). Enter the three digit number of the VA Station which issued the identification card.

Item 14: Do You Have Other Health Insurance? If you are covered under another medical benefits plan or health insurance coverage (to include health coverage available through other family members), check "yes" and supply the name and address of the other health insurer, and what plan or program you have from that insurer.

CHAMPUS will not duplicate benefits of any other health insurance plan or program.

- All beneficiaries must first submit a claim for reimbursement to the other medical care insurer, except if the other coverage is Medicaid. If Medicaid, first submit to CHAMPUS. After receiving an Explanation of Benefits (EOB) or a work sheet from the other health insurer, fill out and file the CHAMPUS/CHAMPVA claim form, attaching a copy of the EOB or work sheet, being sure to complete items 1 through 18 of the CHAMPUS/CHAMPVA claim form.

Item 15: Inpatient/Outpatient Care. Check appropriate space according to the following explanations:

- Outpatient. All eligible CHAMPUS/CHAMPVA beneficiaries may choose Outpatient care from either civilian, Military or Public Health Services facilities. A Nonavailability Statement (DD Form 1251) is not required for outpatient care.
- Inpatient. For admission to a civilian hospital, a Nonavailability Statement (DD Form 1251) is required by all beneficiaries (except CHAMPVA) who live within the catchment area of a Military Treatment Facility or a Uniformed Services Treatment Facility (formerly Public Health Services Facility). A copy of the Nonavailability Statement must be attached to each claim relating to the inpatient stay; i.e., attach a copy to the surgeon's claim, to the anesthesiologist's claim, etc. A Nonavailability Statement is issued by the Military Hospital Commander before medical care is provided.
- Emergency Admission. In the case of a bona fide medical emergency, a Nonavailability Statement is not required for an inpatient admission.
- Outside Catchment Area. A Nonavailability Statement is not required for admission to a civilian hospital when the beneficiary/patient lives outside the catchment area of a Military Treatment Facility or a Uniformed Services Treatment Facility.
- College Infirmary. A Nonavailability Statement is not required for inpatient care in a college infirmary.
- Other exceptions. A Nonavailability Statement is not required for admission to an approved Skilled Nursing Facility, Residential Treatment Center, Specialized Treatment Facility, Christian Science Sanatorium, or for services provided under the Partnership Program.

Item 18: Signature. Every CHAMPUS/CHAMPVA claim must be signed by the beneficiary/patient when that beneficiary is 18 or over. If the beneficiary/patient is unable to sign on his/her own behalf, refer to Fact Sheet 12, "How to File a CHAMPUS Claim." The sponsor may sign for any beneficiary/patient under 18; or in the absence of the sponsor, the beneficiary/ patient's parent or guardian may sign. For reasons of privacy, a beneficiary/patient under 18 may choose to sign and personally submit the claim.

PHYSICIAN / OTHER PROVIDER INFORMATION

Following are explanations of some of the items required when the physician/other provider completes the claim form. For a more detailed explanation of all items, refer to Fact Sheet 12, "How to File a CHAMPUS Claim," available from your nearest Uniformed Services medical facility, your CHAMPUS contractor, or from OCHAMPUS, Aurora, Colorado 80045-6900.

Item 25b: Place of Service Codes.

1 - (IH) - INPATIENT HOSPITAL
2 - (OH) - OUTPATIENT HOSPITAL
3 - (O) - DOCTOR'S OFFICE
4 - (H) - PATIENT'S HOME
5 - (DCF) - DAY CARE FACILITY (PSY)
6 - (NCF) - NIGHT CARE FACILITY (PSY)
7 - (NH) - NURSING HOME
8 - (SNF) - SKILLED NURSING FACILITY
9 - (AMB) - AMBULANCE
0 - (OL) - OTHER LOCATIONS
A - (IL) - INDEPENDENT LABORATORY
B - (OF) - OTHER MEDICAL/SURGICAL FACILITY
C - (RTC) - RESIDENTIAL TREATMENT CENTER
D - (STF) - SPECIALIZED TREATMENT FACILITY

Item 29d: Provider Number. Enter the provider number, including the sub-identifier, assigned by the appropriate CHAMPUS contractor.

Item 32: CHAMPUS Participation. If a provider chooses to participate, check "Yes" in this box. Each provider should carefully read the back of the claim form regarding participation, and understand the agreement with the Government, and the consequences for falsifying any part of the claim form.

Item 33: Signature. Enter the signature of the physician or other provider, or his/her authorized representative. If the physician or other provider completes the claim form, the form must be signed regardless of whether or not he/she agrees to participate as a CHAMPUS provider. See Item 32 on CHAMPUS participation.

IMPORTANT REMINDER

All information in items 1 through 18 is required to process the CHAMPUS/CHAMPVA claim form. Carefully check Item 8, Social Security Number or VA ID Number; Item 5, Identification Card, and Item 18, Signature Identification. Information must also be on all attachments. *Incomplete forms will be returned for completion. Keep a copy of the claim form and all attachments for your records.*

Figure 2-1-A-3 ***Reserved*** I

Figure 2-1-A-4 Suggested Letter Informing The Beneficiary or Participating Provider of The Transfer of Claim(s) to the Correct Contractor

Date of Notice and Transfer: _____
Beneficiary Name: _____
Sponsor's Name: _____
Social Security Number: _____
Provider's Name and Address: _____
Dates of Service: _____

_____
_____
_____

Dear _____:

Your claim(s) for TRICARE benefits has/have been forwarded to _____, the contractor having jurisdiction for the area where your services or supplies were provided. Any questions should be directed to:

(Name, Address, and Telephone Number of the Contractor responsible for processing the claim(s))

Your claim(s) for TRICARE benefits has/have been forwarded to _____, the contractor having jurisdiction for the area of your residence. Any questions should be directed to:

(Name, Address, and Telephone Number of the Contractor responsible for processing the claim(s))

Sincerely,

Figure 2-1-A-5 Suggested Letter Informing the Beneficiary of the Transfer of Part(s) of Claim(s) to the Correct Contractor

Date of Notice and Transfer: _____
Beneficiary Name: _____
Sponsor's Name: _____
Social Security Number: _____
Provider's Name and Address: _____
Dates of Service: _____

_____
_____
_____

Dear _____:

Your claim for multiple providers has been received by our office. The services or supplies provided within our contract jurisdiction are being processed.

The remainder of the services or supplies on the claim have been forwarded to _____, *the* contractor responsible for the area where the services were provided. Since more than one contractor will be processing your claim simultaneously, there is a possibility an excess deductible will be applied. If this occurs, request an adjustment from the processor applying the excess deductible. Include copies of the relevant Explanations of Benefits with your request. Any questions should be directed to:

(Name(s), *Address(es), and Telephone Number(s) of the Contractor(s))*

Sincerely,

Figure 2-1-A-6 Suggested Letter Informing the Claimant that Claim for Active Duty Member has been Forwarded to the Appropriate Uniformed Service

Date of Notice and Transfer: _____

_____
_____
_____

Dear_____:

TRICARE is a medical benefits program provided by the Federal Government to help pay for civilian medical care provided to spouses and children of active duty Uniformed Services personnel, to retirees and their spouses and children, and to spouses and children of deceased active duty and deceased retired personnel. **An active duty member is not eligible for benefits under TRICARE**.

Billings for civilian medical care provided to active duty members are the responsibility of the appropriate Uniformed Services. We have forwarded your claim to the address listed below. Any further questions concerning your claim should be directed to them.

_____
_____
_____
_____

Sincerely,

cc:
(Active duty service member if claimant is the provider.)

Figure 2-1-A-7 Verification of Eligibility, CHAMPUS Form 88R

DETERMINATION OF ELIGIBILITY/CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES

PURPOSE: To determine eligibility of the patient named hereon to receive medical care under the Civilian Health and Medical Program of the Uniformed Services
REFERENCES: DoD 6010.8-R, OCHAMPUS Manual 6010.24-M, OCHAMPUS Manual 6010.50-M

SECTION I (To be completed only by OCHAMPUS, a Fiscal Intermediary, or a CHAMPUS Contractor)

1. TO

PATIENT		SERVICE MEMBER (Sponsor)	
2. NAME (Last, First, Middle Initial)		9. NAME (Last, First, Middle Initial)	10. GRADE/RATE
2a. SOCIAL SECURITY NUMBER		11. SERVICE ☐ USA ☐ USN ☐ USMC ☐ USAF ☐ USCG ☐ PHS ☐ NOAA	
3. RELATIONSHIP TO SPONSOR (If pertinent)	4. DATE OF BIRTH (If pertinent)	12. STATUS ☐ ACTIVE DUTY ☐ RETIRED ☐ DECEASED ☐ NATIONAL GUARD ☐ RESERVES ☐ VA ☐ UNKNOWN ☐ OTHER (Explain in Block 15)	
5. DATE OF MARRIAGE (If pertinent)	6. DATE OF DIVORCE (If pertinent)	13. SOCIAL SECURITY NUMBER	
7. PERIOD OF MEDICAL CARE FROM: THRU:		14. UNIT, POST, BASE OR STATION (AD); HOME ADDRESS (RET)	
8. LAST KNOWN ADDRESS		15. REMARKS	
16. REQUESTOR'S SIGNATURE	17. TITLE	18. ORGANIZATION	19. DATE
20. RETURN TO			

SECTION II (To be completed by the verifying organization and returned to address in item 20)

21. PATIENT'S ELIGIBILITY DURING PERIOD SHOWN IN ITEM 7 IS AS FOLLOWS:
☐ ELIGIBLE DURING ENTIRE PERIOD ☐ NOT ELIGIBLE (Explain in Block 22)
☐ ELIGIBLE DURING PART OF PERIOD: FROM: _____ THRU: _____
☐ CANNOT BE DETERMINED FOR REASONS SHOWN IN BLOCK 22

22. REMARKS

23. SIGNATURE OF VERIFYING OFFICER (Sponsor's signature not authorized)	24. TITLE	25. ORGANIZATION	26. DATE

CHAMPUS FORM 88R JUNE 1990 Previous editions of this form are obsolete (Local Reproduction Authorized)

Figure 2-1-A-8 Provider's Notarized Facsimile or Stamp Signature Authorization

State of _____)
) ss
County of _____)

_____ being first duly sworn, deposes and says: I hereby authorize the **Contractor for TRICARE in the State of** to accept my facsimile or stamp signature shown below

(Facsimile, stamp or computer generated signature as it will appear on the claim form.)

as my true signature for all purposes under TRICARE in the same manner as if it were my actual signature, including my agreeing to abide by the TRICARE payment system concept and the remainder of the certification normally signed by the source of care as it appears on all TRICARE claim forms.

Signature

Subscribed and sworn to before me this _____ day of _____ 19___.

_____
Notary Public in and for

_____County, State of _____

(SEAL)

My Commission expires_____

Figure 2-1-A-9 Provider's Notarized Signature Authorization

State of _____)
) ss
County of _____)

Know all persons by these presents:

That I, _____ have made, constituted and appointed and by these presents do make constitute and appoint _____ my true and lawful attorney-in-fact for me and in my name place and stead to sign my name on claims, for payment for services provided by me submitted to *TRICARE*. My signature by my said attorney-in-fact includes my agreement to abide by the *TRICARE* payment system concept and the remainder of the certification appearing on all *TRICARE* claims forms. I hereby ratify and confirm all that my said attorney-in-fact shall lawfully do or cause to be done by virtue of the power granted herein.

In witness whereof I have hereunto set my hand this _____day of _____ 19___.

Signature

Subscribed and sworn to before me this _____ day of _____19____.

_____
Notary Public in and for

_____County, State of _____

(SEAL)

My Commission expires_____

Figure 2-1-A-10 Nonavailability Statement, DD Form 1251

UNIFORMED SERVICES MEDICAL TREATMENT FACILITY NONAVAILABILITY STATEMENT (NAS)

REPORT CONTROL SYMBOL

Privacy Act Statement

AUTHORITY: 44 USC 3101, 41 CFR 101 et seq., 10 USC 1066 and 1079, and EO 9397, November 1943 (SSN).

PRINCIPAL PURPOSE: To evaluate eligibility for civilian health benefits authorized by 10 USC, Chapter 55, and to issue payment upon establishment of eligibility and determination that the medical care received is authorized by law. The information is subject to verification with the appropriate Uniformed Service.

ROUTINE USE: CHAMPUS and its contractors use the information to control and process medical claims for payment; for control and approval of medical treatments and interface with providers of medical care; to control and accomplish reviews of utilization; for review of claims related to possible third party liability cases and initiation of recovery actions; and for referral to Peer Review Committees or similar professional review organizations to control and review providers' medical care.

DISCLOSURE: Voluntary; however, failure to provide information will result in denial of, or delay in payment of, the claim.

1. NAS NUMBER *(Facility) (Yr - Julian) (Seq. No.)*	2. PRIMARY REASON FOR ISSUANCE *(X one)*
	a. PROPER FACILITIES ARE TEMPORARILY NOT AVAILABLE IN A SAFE OR TIMELY MANNER
3. MAJOR DIAGNOSTIC CATEGORY FOR WHICH NAS IS ISSUED *(Use code from reverse)*	b. PROFESSIONAL CAPABILITY IS TEMPORARILY NOT AVAILABLE IN A SAFE OR TIMELY MANNER
	c. PROPER FACILITIES OR PROFESSIONAL CAPABILITY ARE PERMANENTLY NOT AVAILABLE AT THIS FACILITY
	d. IT WOULD BE MEDICALLY INAPPROPRIATE TO REQUIRE THE BENEFICIARY TO USE THE MTF *(Explain in Remarks)*

4. PATIENT DATA

a. NAME *(Last, First, Middle Initial)*	b. DATE OF BIRTH *(YYMMDD)*	c. SEX
d. ADDRESS *(Street, City, State, and ZIP Code)*	e. PATIENT CATEGORY *(X one)*	f. OTHER NON CHAMPUS HEALTH INSURANCE *(X one)*
	(1) Dependent of Active Duty	(1) Yes, but only CHAMPUS Supplemental
	(2) Dependent of Retiree	(2) Yes *(List in Remarks)*
	(3) Retiree	(3) No
	(4) Survivor	
	(5) Former Spouse	

5. SPONSOR DATA *(If you marked 4e(3) Retiree above, print "Same" in 5a.)*

a. NAME *(Last, First, Middle Initial)*	b. SPONSOR'S OR RETIREE'S SOCIAL SECURITY NO.

6. ISSUING OFFICIAL DATA

a. NAME *(Last, First, Middle Initial)*	b. TITLE	
c. SIGNATURE	d. PAY GRADE	e. DATE ISSUED *(YYMMDD)*

7. REMARKS *(Indicate block number to which the answer applies.)*

DD Form 1251, OCT 88

Figure 2-1-A-10 Nonavailability Statement, DD Form 1251 (Continued)

INSTRUCTIONS TO THE PATIENT

Concerning use by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

1. The medical care requested is not available to you at a Uniformed Services Medical Treatment Facility (USMTF) in this area.

2. This form does NOT guarantee that CHAMPUS will cost share your care.

a. If you receive medical care from civilian sources and such care is determined to be authorized care under CHAMPUS, it will be cost shared by the Government to the extent that the program permits, provided such care is not obtained in a facility which discriminates in its admission and treatment practices on the basis of race, color, or national origin.

b. If you receive medical care from civilian sources and it is determined that all or part of the care is not authorized under CHAMPUS, the GOVERNMENT WILL NOT PAY for the unauthorized care.

c. The determination of whether medical care you receive from civilian sources is covered under CHAMPUS can not be made at this time because this determination depends, among other things, upon the care you actually receive and not upon the statement regarding your condition or diagnosis made on this form.

3. This form must be presented with your Uniformed Services Identification and Privilege Card when you obtain civilian medical care. For your claim to be processed, you must be enrolled in the Defense Enrollment Eligibility Reporting System (DEERS).

4. This form is valid only for medical care requested from and determined not available at a Uniformed Services medical treatment facility in this area.

5. An NAS shall normally be valid only for a hospital admission within 30 days of issuance for the specialty code noted on the NAS. It will remain valid from the date of admission until 15 days after discharge for any other required treatment that is directly related to the original admission, with the following exceptions:

a. In maternity cases, the date of admission is the date when the patient entered into the prenatal care program with a civilian provider, and the maternity NAS shall remain valid for 42 days following termination of the pregnancy.

b. If a newborn infant remains in the hospital continuously after the discharge of a CHAMPUS eligible mother, the mother's NAS shall be valid for the infant in the same hospital for up to 15 days after the mother's discharge. Beyond this 15 day limit, the beneficiary must request the issuing facility to make a determination on the availability of care for the infant and to issue an NAS for the infant if the requirements of these instructions are met.

c. If an active duty service member gives birth in a civilian hospital and there are charges for the care of the infant, an NAS is required for the infant if the infant's stay is for four or more days. (At that point, the infant is considered to be a new CHAMPUS eligible patient in his or her own right.)

d. If you do not use this form within 30 days, or if you have questions about the expiration of the form, you should check with your local Health Benefits Advisor (HBA) prior to your admission to the hospital. If you do not use this form, return it to the issuing Uniformed Services medical treatment facility.

6. If you have further questions regarding this form or your CHAMPUS benefits, you should talk with your local Health Benefits Advisor, the CHAMPUS Fiscal Intermediary for your area, or the Beneficiary and Provider Relations Division, Office of CHAMPUS, Aurora, Colorado 80045-6500.

I HAVE REVIEWED AND UNDERSTAND THE ABOVE INSTRUCTIONS

PATIENT'S SIGNATURE

INSTRUCTIONS FOR COMPLETING DD FORM 1251

This form can be issued only in accordance with the provisions of DoDI 6015.19, "Issuance of Nonavailability Statements," as implemented by the issuing facility's host Service (AR 40-121, NAVMEDCOMINST 6320.3, AFR 168.9, PHS General Circular No. 6, CGCOMDTINST 6320.11b, NOAA CO. 4).

The issuing officer or designee should brief the recipient on the Instructions to the Patient on the front of this form. However, if the patient is not enrolled in DEERS, and the HBA has reason to believe the individual is entitled to care, issue a "conditional" NAS and advise the patient that the claim will not be considered until the DEERS enrollment is complete.

If this NAS is being issued retroactively (after the date the patient was admitted to the hospital), the last three digits of the NAS Number, Block 1, must be between 900 and 999 and an explanation provided in Block 7, "Remarks." If this condition is not met, the CHAMPUS Fiscal Intermediary will reject the claim.

1. Enter an NAS Number.
   - The first four digits are the Defense Medical Information System (DMIS) facility identifier.
   - The next four digits represent the date the form is issued. It consists of the last digit of the year plus the Julian Date. (For example, if the date is 1 January 1988, these digits would be 8001.)
   - The final three digits are the facility sequence number:
     - Numbers 000 through 899 may be assigned in accordance with the implementing instructions of the issuing facility's host Service.
     - Numbers 900 through 999 are assigned to NAS's issued retroactively. Enter the civilian hospital name and admission date for which the NAS applies in Block 7, "Remarks."

2. Mark the appropriate box.

3. Enter the code for the major diagnostic category for which the NAS is being issued from the following list. For further information on what goes into each category, consult the Diagnostic Related Group (DRG) Definitions Manual.

01 Diseases and Disorders of the Nervous System
02 Diseases and Disorders of the Eye
03 Diseases and Disorders of the Ear, Nose and Throat
04 Diseases and Disorders of the Respiratory System
05 Diseases and Disorders of the Circulatory System

3. Codes (Cont'd)

06 Diseases and Disorders of the Digestive System
07 Diseases and Disorders of the Hepatobiliary System and Pancreas
08 Diseases of the Musculoskeletal System and Connective Tissue
09 Diseases of the Skin, Subcutaneous Tissue and Breast
10 Endocrine, Nutritional and Metabolic Diseases
11 Diseases and Disorders of the Kidney and Urinary Tract
12 Diseases and Disorders of the Male Reproductive System
13 Diseases and Disorders of the Female Reproductive System
14 Pregnancy, Childbirth and the Puerperium
15 Normal Newborns and Other Neonates with Certain Conditions Originating in the Perinatal Period
16 Diseases and Disorders of the Blood and Blood-Forming Organs and Immunological Disorders
17 Myeloproliferative Disorders and Poorly Differentiated Neoplasms
18 Infectious and Parasitic Diseases (Systemic or Unspecified Sites)
19 Mental Diseases and Disorders
20 Alcohol/Drug Use and Alcohol/Drug Induced Organic Disorders
21 Injuries, Poisonings, and Toxic Effect of Drugs
22 Burns
23 Factors Influencing Health Status and Other Contacts with Health Services
60 Pediatrics

4a-e. Self-explanatory.

4f. Mark the appropriate box. If "f(2), Yes," is marked, specify the name of the insurance company and the policy number, if available, in Block 7, "Remarks."

5a. Enter the Sponsor's name. If the sponsor is the patient, enter "Same." 5b is self-explanatory.

6a-d. Self-explanatory.

6e. This date should be the same as the date in Block 1, but written in YYMMDD format.

7. Enter remarks as required by these instructions and implementing instructions.

DD Form 1251 Reverse, OCT 90

Figure 2-1-A-11 ***Reserved***

Figure 2-1-A-12 Abortion Denial Notice to the Beneficiary and Participating Provider

Date: _____
Sponsor's Name: _____
Beneficiary's Name: _____
Type of Service(s): _____
Date of Service(s): _____
Sponsor's SSN: _____

PERSONAL

To: _____
_____
_____

Dear _____:

The Congress has prohibited *TRICARE* coverage of abortion service, except where the life of the mother would be endangered if the fetus were carried to term.

The legislation which limits abortion coverage applies two different effective dates to groups of *TRICARE* beneficiaries. For active-duty military dependents, and military retirees and their dependents, as well as survivors of deceased military members--except for the Coast Guard, the Commissioned Corps of the Public Health Service and the National Oceanic and Atmospheric Administration--the limitation is retroactive to December 29, 1981.

For dependents and retired personnel of the Coast Guard, the Commissioned Corps of the Public Health Service, and the National Oceanic and Atmospheric Administration, the limitation on coverage is retroactive to June 5, 1981.

This means that abortions--except in life-threatening situations--that were performed after these effective dates, will **not** be cost-shared by *TRICARE*.

Initial review of the claim(s) gave no indication that the circumstances of the abortion would qualify under this exception. Therefore, your claim(s) related to the abortion performed on _____ must be denied.

If you believe the circumstances of the abortion do qualify under the exception, you may request a Reconsideration of the denial decision by submitting a written request for a Reconsideration to this office within 90 days of the date of this notice. Such request must include a copy of this notice and your statement of the matter in dispute along with certification from the attending physician that the abortion was performed because the woman was suffering from a condition that would have endangered her life if the fetus were carried to term. Additional information/documentation which will support your claim should be submitted with your request.

Figure 2-1-A-12 Abortion Denial Notice to the Beneficiary and Participating Provider (Continued)

If you have any questions concerning the *TRICARE* abortion policy, you are urged to contact your Health Benefits Advisor (located at the nearest Uniformed Services medical facility) for more detailed information. You may also contact **(Contractor Name and Address.)**

Sincerely,

Figure 2-1-A-13 Suggested Format for Information Obtained from Existing File Data or by Telephone

Date Information Obtained: _____

Beneficiary Name: _____

Sponsor Name: _____

Internal Control Number (ICN): _____

Source of Development: ☐ Existing File Data

Check one block **only** and complete blank below that block).

Name of file or ICN of previously processed claim if data is claim specific _____

☐ Telephone

Name of Person Providing Information

_____

Type of Claim:

☐ Claim Form 2520 ☐ Claim Form 1500 ☐ UB-92 ☐ Other

Item Completed _____ ***(Information Obtained)*** _____

_____

Initials or Signature of Person Obtaining Information

THIS DOCUMENT IS TO BE MICROFILMED OR IMAGED AS PART OF THE CLAIM RECORD (THIS DOCUMENT MAY ALSO BE MAINTAINED ON AN ELECTRONIC RECORD). SEE THE OPM PART TWO, CHAPTER 1, SECTION V.B.2.B.

Privacy Act Statement:

In view of the fact that personal information is being requested from you, notice is hereby given as required by the Privacy Act of 1974. The information is requested and maintained under the authority of Chapter 55, Title 10, United States Code, Section 3101, Title 44, United States Code, and 41 Code of Federal Regulations 101-1100 ***et seq****. The information is requested to establish or update information to control or process claims for payment. Routinely, the information will be used to determine eligibility for TRICARE benefits, review and approve medical care as TRICARE benefits, and to determine reasonable charges/costs of care to be cost-shared under TRICARE. Disclosure of the information is voluntary; however, failure to provide the information will result in denial of benefits.*

Figure 2-1-A-14 Sample MHS Catchment Area Directory

VOLUME I, INPATIENT FL-4 INPATIENT CATCHMENT AREA NARMC PENSACOLA ZIP CODES INCLUDED IN CATCHMENT AREA (CONTINUED)					
ZIP CODE	TOWN NAME	STATE	STATUS	DISTANCE	NEW CNA
36535	FOLEY	AL	Z	22	YES
36536	FOLEY	AL	Z	22	YES
36542	GULF SHORES	AL	Z	22	YES
36549	LILLIAN	AL	Z	8	YES
36551	LOXLEY	AL	Z	32	YES
36555	MAGNOLIA SPRINGS	AL	Z	28	YES
36559	MONTROSE	AL	Z	37	YES
36561	ORANGE BEACH	AL	Z	15	YES
36564	POINT CLEAR	AL	Z	37	YES
36567	ROBERTSDALE	AL	Z	27	YES
36574	SEMINOLE	AL	Z	14	YES
36576	SILVERHILL	AL	Z	29	YES
36578	STAPLETON	AL	Z	39	YES
36580	SUMMERDALE	AL	Z	25	YES

Figure 2-1-A-15 Zip Code File Layout, File Description

COLUMN	DATA DESCRIPTION
FILE 1:	**1986 INPATIENT MTF CODES**
1	Blank
2-4	MTF ID Code
5	Blank
6-64	MTF Name
65-66	State Abbreviation (of MTF)
67	Blank
68	Service Branch of MTF: 1 = Army 2 = Navy 3 = Air Force 4 = Coast Guard 5 = U.S. Treatment Facility
FILE 2:	**1986 INPATIENT CATCHMENT AREA DIRECTORY (includes USTF Hospital catchment areas)**
1	Blank
2-4	MTF ID Code
5	Blank
6-10	5 Digit Zip Code
11	Blank
12-30	Town Name
31-32	State Abbreviation of Zip code
33	Blank
34-35	Distance Between Zip Code and Facility (Miles)
36	Blank
37-38	Status Code (Included in the DMIS Catchment Area Directory)
39	New CNA 0 = Yes 1 = No Blank = Uniformed Services Treatment Facility (USTF) Catchment Area

Figure 2-1-A-15 Zip Code File Layout, File Description (Continued)

COLUMN	DATA DESCRIPTION
File 3:	ZIP CODE/MTF LINKAGE
1	Blank
2-6	5 Digit Zip Code
7	Blank
8-10	1st MTF Attached to Zip Code
11	Blank
12-14	2nd MTF Attached to Zip Code (If Applicable)
15	Blank
16-18	3rd MTF Attached to Zip Code (If Applicable)
19	Blank
20-22	4th MTF Attached to Zip Code (If Applicable)
23	Blank
24-26	5th MTF Attached to Zip Code (If Applicable)
27	Blank
28-30	6th MTF Attached to Zip Code (If Applicable)
31	Blank
32-34	7th MTF Attached to Zip Code (If Applicable)
35	Blank
36-38	8th MTF Attached to Zip Code (If Applicable)
39	Blank
40-42	9th MTF Attached to Zip Code (If Applicable)